Memorandum

Date : January 3, 2006

To : Rod Hickman, Secretary
Department of Corrections and Rehabilitation

Subject: REVIEW OF STAFF SAFETY EVALUATION CORRECTIVE ACTION PLANS

The Corrections Standards Authority (CSA) has received correction actions plans from the Division of Juvenile Justice (DJJ) for Staff Safety Evaluations conducted at the following institutions:

- Preston Youth Correctional Facility
- N.A Chaderjian Youth Correctional Facility
- O.H. Close Youth Correctional Facility
- DeWitt Nelson Youth Correctional Facility

In response to the corrective action plans, the CSA developed an Executive Summary highlighting key findings from the Staff Safety Evaluation Reports and the elements of the corrective action plans. The summary is attached to this memo.

It is apparent that considerable thought and effort went into the development of the plans. Many of the findings have already been addressed or corrected; others will be addressed as part of the *Farrell* mediation plan or following a scheduled training needs assessment process. The findings requiring resources beyond those available to the DJJ are or will be addressed by Budget Change Proposals. There were only a few findings in which DJJ was not in concurrence and the rationale for non-concurrence was appropriate.

Thank you for the opportunity to review the corrective action plans. Please do not hesitate to contact me if you have any questions.

Jerry A. Read
Deputy Director (A)
Corrections Standards Authority

cc: Jeanne Woodford, Undersecretary
Bernard Warner, Chief Deputy Secretary

CORRECTIONS STANDARDS AUTHORITY

REVIEW OF CORRECTIVE ACTION PLANS

PRESTON YOUTH CORRECTIONAL FACILITY
O.H. CLOSE YOUTH CORRECTIONAL FACILITY
DEWITT NELSON YOUTH CORRECTIONAL FACILITY
N.A. CHADERJIAN YOUTH CORRECTIONAL FACILITY

January 2006

Department of Corrections and Rehabilitation
Corrections Standards Authority
600 Bercut Drive
Sacramento, CA 95814
www.csa.ca.gov

EXECUTIVE SUMMARY

The Staff Safety Evaluation Team, created by the Corrections Standards Authority (CSA) in response to concerns about institutional safety, conducted evaluations of the following four Division of Juvenile Justice (DJJ) facilities: Preston Youth Correctional Facility (Preston) July 12-15, 2005, and the three facilities that make up the Northern California Youth Correctional Center - N.A Chaderjian (Chad), O.H. Close (Close) and DeWitt Nelson (DeWitt) Youth Correctional Facilities August 3-18, 2005. A panel of correctional experts developed the criteria upon which the evaluations are conducted and one of their objectives was to avoid duplicating audits, inspections and evaluations that were already conducted. As such, the scope of these evaluations has been limited to specific issues concerning staff assaults, training, safety equipment, staffing, physical plant issues and interviews with staff.

STAFF SAFETY EVALUATION FINDINGS

As a result of the July and August 2005 evaluations, the Staff Safety Evaluation Team identified a number of findings, the majority of which fall into five categories: physical plant, staffing, training, policies and procedures, and safety equipment. Attachment A lists 108 findings that applied to one or more of the four facilities. The key findings are as follows:

Physical Plant

- The lack of physical plant maintenance and poor design features contribute to an unsafe environment at Chad, Close, and Dewitt. The apparent neglect of these facilities is evident throughout each including locks that can be defeated by wards, a lack of floor drains resulting in flooding, inadequate fencing to prevent wards from scaling interior fences, inoperative plumbing, etc.

- The work order tracking system utilized by Plant Operations at Chad, Close, and Dewitt is ineffective and contributes to the maintenance issues.

- There is a lack of program/housing space for violent prone wards.

Staffing

- At times, there is an inadequate number of custody and correctional counselors available to perform necessary duties at Preston, Chad, Close, and Dewitt.

- The lack of adequate staffing has resulted in mandatory overtime at Preston, Chad, Close, and Dewitt. The end result is an increase in sick leave usage and the lowering of staff morale.

- The use of staff in vehicles to monitor ward movement and to provide minimal "patrol" functions is ineffective at Preston, Chad, Close, and Dewitt.

- Supervisors (custody and youth correctional counselors) do not consistently monitor the activities of security staff at Chad, Close, and Dewitt.

- Supervisors are used to backfill vacant line staff positions resulting in their inability to perform supervisory duties.

- There are not an adequate number of teachers and maintenance staff at Chad, Close, and Dewitt.

Training

- DJJ custody staff, correctional counselors, senior correctional counselors, and supervisors are not receiving the required number of hours to meet their mandated annual training.
- DJJ does not have a formal facility training officer (FTO) program to provide structured training to new staff. FTO programs ensure that new staff are competent in their duties before they are allowed to perform the duties unsupervised.
- DJJ does not provide formal training for Facility Training Officers (facility staff selected to train newly appointed officers).
- DJJ staff needs to receive formal training in how to deal more effectively with mentally ill wards.
- An annual training plan needs to be developed and implemented for all DJJ staff.

Policy and Procedures

- Policy and Procedures Manuals are outdated, inconsistent and not reflective of current operations.
- Post orders are outdated, generic, and have no signatures of authority, and there is no process in place to ensure that staff have read and understand the post orders.
- Emergency response protocols need to be reviewed and staff needs training in responding to emergencies.
- The DJJ lacks a formal objective ward classification system to meet the security and custody needs of each facility.
- Emergency fire evacuation drills are not routinely conducted at Preston, Chad, Close, or Dewitt.
- There were inadequate tool control policies and procedures in some instances.

Safety Equipment

- Stab vest inventories are not maintained or refurbished; therefore, staff may not have vests issued or available to them at Chad, Close, or Dewitt.
- Personal alarms work intermittently or not at all at Preston, Chad, Close, and Dewitt.
- The transportation vehicles at Preston have outlived their useful life (average more than 179,000 miles), are unreliable (leading to unsafe situations), and in need of replacement.
- There are an inadequate number of handheld radios available for staff use at Preston, Chad, Close, and Dewitt. Secondarily, there is an insufficient supply of "charged" batteries available for oncoming shifts.
- Staff at Chad would benefit from protective equipment (e.g., face shields) to protect them from incidents of gassing that are prevalent there.
- A process for replacing Oleoresin Capsicum (OC) spray canisters on an as-needed basis needs to be developed.

DJJ CORRECTIVE ACTION PLANS

As a result of the evaluations and subsequent reports, the Division of Juvenile Justice developed corrective action plans to address each of the findings. The responses to key findings are as follows:

Physical Plant
A multi-facility committee has been established to oversee and conduct an evaluation of maintenance needs for all DJJ facilities with a completion date of March 1, 2006. Those issues that can be remedied with existing resources will be addressed immediately; those beyond existing resources will be forwarded to the Office of Facilities Management and a Budget Change Proposal (BCP) submitted as necessary. In some instances, BCPs have been approved for physical plant deficiencies and the institution management is awaiting funding or for work to begin. Memos have been issued to staff at Chad reminding them to ensure doors are properly secured when closed and to immediately report malfunctioning doors. DJJ is also arranging an assessment of the locking systems.

DJJ is exploring options for the establishment of an automated work order tracking system and will work with the Office of Facilities Management to develop an effective manual system for use until an automated system is available.

As part of the *Farrell* remedial planning process, DJJ is consulting with nationally recognized experts to assist in design, development and implementation of additional rehabilitation/treatment interventions, specifically in the areas of violence reduction, gang integration, substance abuse/dependence and normative culture.

Staffing
DJJ reports that the *Farrell* remediation plans will address staffing issues through reduced living unit population and increased staffing.

In regard to teaching vacancies, DJJ staff in conjunction with Education Services will continue efforts to recruit educational staff, including teachers and substitutes. Principals will conduct ongoing hiring interviews.

The safety, security, and programmatic implications of vehicle use within the security perimeters of DJJ facilities will be assessed by a work group designated by the Director, Division of Juvenile Facilities. The group will prepare a recommended standardized policy for vehicle use within DJJ facilities.

Training
DJJ has begun a training needs assessment and intends to develop lesson plans to address needed training.

Policy and Procedure
DJJ will prepare a comprehensive plan for the establishment of current standardized institutional operations manuals by March 1, 2006.

Post orders will be updated by February 1, 2006 and will be audited to ensure they are being read and understood.

DJJ will place emergency response procedures and the use of force policy in a binder in each living unit and communication center by December 14, 2005.

DJJ is developing a comprehensive statewide classification system as part of the *Farrell* remediation plan.

DJJ has developed a schedule for fire drills and has recently conducted and documented fire drills.

DJJ will assemble a committee of Senior Youth Correctional Counselors to develop a plan and submit a proposal to the Superintendent's Office regarding tool accountability on the living units (scissors, barber tools, brooms, mops, etc.). The plan is to be implemented on January 5, 2006. The plan will include quarterly audits of tool accountability on the living units to ensure compliance with the instructions issued.

Safety Equipment

DJJ plans to develop a tracking system to monitor the expiration date of vests. The current inventory tracking process will be revised to include a column for the expiration date of vests. There is currently a Department-wide program to update and increase the number of vests provided to staff.

The personal alarm system is being replaced. This will eliminate the concerns cited in the evaluation reports, as the new system will have a single alarm zone.

The transportation fleet has not been replaced on schedule. Purchase orders have been prepared to replace all eight transportation vehicles and are pending budget approval. Adult Operations Division has loaned three vans to DJJ.

Office of Facility Management/Radio Communications Unit (RCU) completed an assessment of the DJJ facility radio systems. RCU recommends DJJ purchase radios and equipment as needed and will schedule training and provide a training manual in the proper use and operation of hand held radios. RCU recommends participating in the statewide 800 Mhz radio system rebanding project covering all law enforcement agencies in California.

Face shields have been ordered for each living unit at Chad. Bloodborne pathogen clothing is available on each unit for staff.

DJJ has established institutional standards for checking OC canisters and developing an appropriate replacement schedule. In addition, DJJ plans to conduct quarterly audits of OC canister records to ensure compliance with established standards.

As the majority of the responses contained in the correction action plans include projected completion dates, it is imperative that the plans are monitored to ensure that results are achieved. Some completion dates were listed as "to be determined," which makes the monitoring task and accountability more difficult. The CSA does not have the resources to monitor the corrective action plans, and we recommend that DJJ Chief Deputy Secretary Bernard Warner or his designee be responsible for this task.

The CSA appreciates the cooperative working relationship we have encountered with the staff of DJJ. The staff safety evaluation process has been well received. Institution management and staff have been forthcoming and recognize that the purpose is to improve staff safety. We look forward to observing the changes.

DJJ FACILITIES

Item*	Recommendations/Description	Preston	Chad	Close	DeWitt
1.	*The lack of maintenance for the entire complex contributes to an unsafe environment.*		X	X	X
2.	*Plant Operation staff has indicated that the original facility construction was substandard in several building trades. Improperly installed wiring for security devices and complete electrical systems; HVAC systems that were ten years old when installed; block walls that were not filled with concrete and substandard plumbing were highlights of discussions. In many instances maintenance is not the issue, but complete replacement of entire systems is needed.*		X		
3.	*Staff reported that the wards have the ability to defeat the locking mechanisms on all of the sleeping rooms within this facility.*		X		
4.	*High temperatures were noted within each of the lodges.*	X			
5.	*Unit I, Sacramento and Kern recreation yard fences are not suitable for use due to the material used and the methods used to secure the individual recreation area (IRA) enclosures.*		X		
6.	*The security perimeter fences surrounding the exercise yards of Units II, III, IV, V and VI are not secure.*		X		
7.	*Partitioning the current living units and creating four halls within each unit is a cost effective means of reducing the number of wards within each hall, increasing staff and ward safety and enhancing program opportunities.*		X		
8.	*Floor drains are not provided in any of the units. Wards are able to substantially flood the halls.*		X		
9.	*The work order tracking system currently utilized by Plant Operations and the facility is ineffective.*		X	X	X
10.	*There is heavy plant growth between the perimeter fences that could conceal contraband or aid in escapes. In some cases, the heavy plant growth is a fire hazard.*	X	X	X	X
11.	*Direct supervision of security staff is not being accomplished.*		X	X	X
12.	*Several vacancies exist among the management staff at NACYCF. This is particularly noteworthy considering that this facility houses some of the most difficult to manage wards and is the recipient of intense media scrutiny regarding allegations of poor management, employee misconduct and excessive violence.*		X		

Item*	Recommendations/Description	Preston	Chad	Close	DeWitt
13.	*Additional staff should be assigned to Units III, IV, V, VI and McCloud Hall in Unit II.*		X		
14.	*At times, there are too few security and escort staff to safely respond to emergencies within the facility.*		X	X	X
15.	*Using lodge officers as escort officers dilutes the staff to ward ratio during heavy movement periods.*	X			
16.	*The housing unit control booths should not be staffed with YCC's.*		X		
17.	*Current staffing patterns do not allow for the Senior Youth Correctional Counselors (SYCC) to adequately supervise the YCCs assigned to each hall housing wards.*		X	X	X
18.	*Staffing levels among teaching staff may be an underlying cause for concern for staff safety.*	X	X	X	X
19.	*Staffing levels among maintenance staff may be an underlying cause for concern for staff safety.*		X	X	X
20.	*The use of staff in vehicles to monitor ward escort/movement and some "patrol" functions is ineffective.*		X	X	X
21.	*Transportation officers reported that the average vehicle used to transport wards is more than five years old and has odometer readings in excess of 179,000 miles.*	X			
22.	*Current staffing levels have resulted in mandated overtime for custody staff.*	?	X	X	X
23.	*The DJJ lacks a formal objective classification system. The current method for determining ward facility and housing assignments fails to account for the security and custody needs of the youth.*	X	X	X	X
24.	*Staff reported that emergency fire evacuation drills are not being conducted.*	X	X	X	X
25.	*There is no accountability for tools maintained in the living units.*	?	X	X	X
26.	*The Institutional Policy Manual needs to be reviewed and updated. Post orders for the YCC and YCOs do not contain the signature of authority or date of revision. There is no process in place (in the units) to ensure staff has read and understand the requirements of the post orders (post order acknowledgement).*	X	X	X	X
27.	*The Institutional Policy Manual sections pertaining to emergency response and staff accounting need to be reviewed and updated.*	X	X	X	X
28.	*Post orders located within each living unit were generic and outdated. They did not reflect current practice.*	X	X	X	X

Item*	Recommendations/Description	Preston	Chad	Close	DeWitt
29.	*Hair care service areas are located within the program center. The post orders do not include a regular documented inventory/accounting of the tools used in the hair care area.*	X			
30.	*Staff was unable to produce current policy and procedures regarding emergency procedures, deployment of chemical agents, or daily operations procedures.*		X	X	X
31.	*There are no procedures in place to address the use of the 37-millimeter gas guns maintained in the unit control booth on Unit I and in the school control booth.*		X		
32.	*The inventory for hazardous materials is not consistently maintained. There are no visual Material Safety Data Sheets (MSDS) placed on the outside of the cleaning material storage units and additional training and supervision is necessary for wards using the materials.*	X			
33.	*A large amount of combustible paper products was noted in ward areas throughout the facility.*	X			
34.	*Post orders for the YCC and YCOs do not contain the signature of authority or date of revision. There is no process in place (in the units) to ensure staff has read and understand the requirements of the post orders (post order acknowledgements).*		X	X	X
35.	*Staff indicated that individuals are assigned to the emergency response teams as they report to work. The unit post orders did not delineate responsibility for emergency response. In addition, unit staff was uncertain as to who would respond to incidents or emergency situations and what security equipment to take.*		X	X	X
36.	*No documentation was present to support that area searches are being conducted.*		X	X	X
37.	*The Chaplain was unaware of duty statements that would provide guidance to the religious staff working in the chapel. The chapel area did not contain areas clearly marked as out of bounds.*	X			X
38.	*The current staffing for general population units needs to be increased due to the violence and increased occurrence of staff assaults.*		X		
39.	*Wards assault staff in an effort to be transferred to an adult facility.*		X		
40.	*A variety of assault methods were used against staff members (the majority were gassings).*		X		

Item*	Recommendations/Description	Preston	Chad	Close	DeWitt
41.	*There are an alarming number of the staff assaults that are committed via the sleeping room food ports.*		X		
42.	*Gang entrenched wards "game" the system, allowing them to control their environment. The segregation of rival gangs has led to empowering the strongest gang at the facility.*		X		
43.	*Staff are targeted by wards for assaults. Entrenched gang members direct retaliatory assaults against staff.*		X		
44.	*Protective clothing and face shields could reduce the potential for injury from gassing.*		X		
45.	*Data on the subject of staff assaults are difficult to capture and analyze. Reporting of staff assaults needs to use similar reporting criteria. A central tracking system for incidents, particularly regarding staff assaults, would provide more meaningful data and trends may be identified as a result.*	X			
46.	*Line staff believes that the "Open Program" rewards wards assigned to Unit I for disciplinary action.*		X		
47.	*Staff says the Disciplinary Decision Making System (DDMS) is cumbersome, and that wards are not deterred by the consequences.*	?	X	?	?
48.	*The number of incidents of staff assault are more frequent in three living units where vests are not available than in the living unit where vests are mandated.*	X			
49.	*Statistics indicate gang influence is responsible for an alarming number of staff assaults. Wards with gang affiliations are more likely to commit assaults on staff. Wards in special management programs and Norteño gang members are responsible for the majority of staff assaults.*		X		
50.	*Injuries do not appear to be initially well documented.*	X			
51.	*Supervisors concurred with management that the possible closures will result in increased assaults, and staff is deeply concerned for their personal safety.*	X		X	
52.	*Statistics provided by the safety officer support the need for increased training in areas including ward relations, officer safety and emergency responses. Reinforcement by supervision at all levels is needed to ensure the information received during the training is applied in the workplace.*		X	X	X
53.	*Custody staff appears to be receiving training in safety related issues, but mandated annual training hours are not being completed.*	X	X	X	X

Item*	Recommendations/Description	Preston	Chad	Close	DeWitt
54.	*Perishable skills training specific to armed assignments has not been documented.*		X		X
55.	*Tracking attendance and ensuring all persons actually attend training as scheduled remains a challenge for the Training Manager. The team members were concerned that not all officers were trained on the appropriate subjects. A dedicated manager may ensure all staff receives appropriate training.*	X	X	X	X
56.	*The Supervisors are not receiving annual refresher training necessary for their positions including effective supervision, leadership, discipline and contract agreements.*	?	X	X	X
57.	*Training records do not reflect that YCCs are receiving training updates specific to ward counseling and supervision.*	?	X	X	X
58.	*A minimum of 16 hours of institutional orientation is mandated for all new staff before assuming ward supervisory duties. The training is being done for the custody staff. It was unknown if the orientation was being done for non-custody and medical staff.*		X		X
59.	*Formal orientation training is not provided to non-custody staff prior to their assignments.*			X	
60.	*Policies for orientation and training of non-custody staff have not been updated since 1999. Many non-custody staff receive little or no initial training or new employee orientation.*	X		X	
61.	*No special training is provided to staff members specific to officer safety in combative/assaultive situations.*	X	X	X	X
62.	*No special training is provided to staff members who act as training officers for purposes of orientation training.*	X	X	X	X
63.	*No formal training is in place to provide "field training" to newly appointed officers.*	X	X	X	X
64.	*An annual training plan needs to be developed for the facility in concert with an agency-wide annual training plan.*	X	X	X	X
65.	*Training deficiencies could be improved through better coordination and by forming partnerships to maximize the use of all available training resources.*	X	X	X	X
66.	*The personal alarm systems used by staff are undependable.*	X	X	X	X
67.	*The personal alarm system utilized by the facility is comprised of several systems. Each system is zone specific and staff must know what zone they are in and have the proper alarm actuator for the system to work.*	X	X	X	X

Item*	Recommendations/Description	Preston	Chad	Close	DeWitt
68.	*Staff were provided radios; however, in most cases the radios were turned off.*	X			
69.	*Staff reports there are not enough personal radios for all staff and that the batteries in the personal radios assigned to them do not hold a charge. Furthermore, the staff does not have the capability of charging the batteries on the unit and must request another battery from central control. Staff reported that, at times, four to five battery changes are needed per shift.*		X	X	X
70.	*Officers are provided safety equipment as specified by policy, but the inventory of specific items may be insufficient due to the facility size and design.*	X	X	X	X
71.	*The current design of Preston does not lend itself to the current best practices of managing the incarcerated juvenile population and is not congruent with the mission of the Juvenile Justice Division.*	X			
72.	*Staff is assigned Oleoresin Capsicum (OC) spray canisters. These canisters are not checked regularly and there is no procedure in place to ensure the canisters are operable.*		X	X	X
73.	*Line staff is concerned about their safety because of the inadequacy of their OC spray for group application.*			X	
74.	*Line staff would like 37/40 mm munitions delivery systems available as a use of force option on the units due to the perceived effectiveness of the system.*		X		
75.	*The proximity of wards to the armory and the security of the cabinetry containing the munitions create an unsafe condition.*				X
76.	*The sub-armory lacks adequate oversight and documentation.*		X	X	
77.	*Security and Escort (S&E) officers indicated that they do not have tactical vests available to them.*		X		
78.	*Some vests will need to be replaced and a replacement program has not been instituted.*		X	X	X
79.	*Low morale has increased the use of sick leave by line staff, which results in staff being held over to cover vacant shifts.*		X		X
80.	*The absence of regular staff results in interruption of programs, as replacement staff is usually an intermittent employee, who is not trained to facilitate group counseling sessions.*		X		X
81.	*Due to their temporary detention or special management program status, the wards in the Ironwood Lodge did not have access to the outdoor recreation areas.*	X			

Item*	Recommendations/Description	Preston	Chad	Close	DeWitt
82.	*Teaching staff indicates that the transfer of information between custody and teaching staff does not always occur in a timely fashion. At times, this information pertains to security issues that affect the entire institution.*	X			
83.	*Effective communication and training of staff has been impacted by the lack of budget resources.*		?	?	X
84.	*The facility does not practice monthly fire drills.*	X	X	X	X
85.	*Staff vacancies and inversing staff has led to an increase in sick leave.*		?	?	X
86.	*Personal alarms or radios work intermittently, thereby compromising staff safety.*	X	X	X	X
87.	*These programs are intensified as they deal with the most difficult and troubled wards. It is essential that there is a sufficient number of qualified and trained staff available at all times. (Lassen, Modoc, and Yosemite)*				X
88.	*There is a crucial need to have adequate programming space for assaultive wards.*	X			
89.	*Custody staff needs training in how to deal more effectively with mentally ill wards.*	X	X	X	X
90.	*Specialized/Intensive Treatment programs treat the most difficult and troubled wards. It is essential that there are a sufficient number of qualified and trained staff available at all times. Currently, there are not a sufficient number of psychologists onsite to provide treatment for these wards.*	X			
91.	*Some counselors said that staff safety is compromised when a disruptive ward remains in a dorm.*	X			X
92.	*It is critical that the facility be allowed to maintain adequate programming space for assaultive wards, specifically Inyo Hall.*	X	X	X	X
93.	*Some type of transitional intervention program is needed for handling assaultive or violence prone wards.*	X	X	X	X
94.	*Some staff said that counselors isolate themselves in the youth counselor station.*				X
95.	*Instead of remaining in the Communications Center to direct, the watch commander responds to emergency situations and direct operations.*	?	X	?	?
96.	*Staff are uncertain of their duties during an emergency because they have not participated in emergency response drills.*	X	X	X	X
97.	*Staffing and procedures for ward suicide watch at the Outpatient Housing Unit (OHU) should be reviewed by the DeWitt Nelson administration.*				X

Item*	Recommendations/Description	Preston	Chad	Close	DeWitt
98.	*The recent addition of a staff member in the Sequoia Lodge on weekdays should be designated as a permanent seven day a week post.*	X			
99.	*There is a need for additional custody staff, especially on the second watch.*			X	
100.	*Supervisors need to supervise and not be utilized to backfill line positions. Additional custody staff, especially on the second watch, is needed.*	X	X	X	X
101.	*When teaching staff does not report for work for various reasons, a substitute is not brought in. As a result, wards are returned to their living unit to wait until the next period to return to the school program.*	X	X	X	X
102.	*There is a need for additional program space for disruptive wards. All line staff stated the need for additional ward supervision (custody) staff.*	X	X	X	X
103.	*Staff assaults have reduced the availability of regular staff who facilitate some of the treatment programs.*		X		
104.	*The nurses working at the specialized and intensive treatment programs felt safer than the nurses assigned to the clinic.*	X			
105.	*Line staff said they feel safer working in a program post assignment.*		X		
106.	*Wards housed at Sacramento Hall, who are restrained when out of their rooms, are allowed to participate in the academic classroom unrestrained. There are inadequate staff in the classroom to quell a disturbance if these special management wards were to act out violently.*		X		
107.	*While they are working in a classroom, the teachers feel that their reports of ward miscondcut have no clout.Tthe teachers would like to see a more visible presence of uniform custody officers.*			X	
108.	*There needs to be a more visible presence of uniform custody officers while wards are in the classroom moving to and from the classrooms and in the gymnasium.*	X			

*** Item numbers do not correspond to the finding numbers used in the corrective action plans.**